NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
NURSING HOME LICENSURE AND CERTIFICATION SECTION
2711 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2711
TELEPHONE: (919) 855-4520

FOR OFFICIAL USE ONLY

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Check No: _____
Amount: _____

2008

APPLICATION FOR LICENSE TO OPERATE A NURSING HOME
(Including Adult Care Home Beds in Combination Facilities)

LEGAL IDENTITY OF APPLICANT:

_____

_____

{Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.}

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMARY: _____
Other: _____
Other: _____

If the above names are **NOT IDENTICAL** to the names on the current license, please check reason for the change:

___ Change of Ownership/Licensee _____ Facility Name Change
___ Other (Specify): _____

NORTH CAROLINA LICENSE NUMBER: _____

FEDERAL TAX ID NUMBER: _____

FACILITY MAILING ADDRESS:

Street/P O Box: _____

City: _____ State: _____ Zip: _____-_____
(Ex. 27626 - 0530)

FACILITY SITE:

Street: _____

City: _____ County:_____

Telephone: (____)_____ Zip: _____-_____

Fax: (____)_____

E-mail Address for Administrator: _____

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or the provision of services."

PART A OWNERSHIP AND MANAGEMENT DISCLOSURE

1. The following information is required by Nursing Home Licensure Rule 10A NCAC 13D .2101. YOUR LICENSE CANNOT BE ISSUED WITHOUT THIS INFORMATION.

   a. What is the name of the **LEGAL ENTITY** with the ownership responsibility and liability? If Corporation, the exact wording of the corporate name as on file with the NC Secretary of State (Corporate Office). If Unit of Government, the name of the unit which has ownership responsibility and liability for the services offered.

   NAME: _____

   b. MAILING ADDRESS:

   Street/Box: _____

   City: _____ State: _____ Zip: _____

   Telephone: (___) _____ Fax: (___) _____

   SENIOR OFFICER: _____

   c. Indicate the Percent of Ownership of the Legal Identity: _____

   d. Is legal entity: (check one)
   For Profit _____ Not For Profit _____

   e. Is the legal entity a: (check 1, 2, 3 or 4)

   (1) PROPRIETOR ____

   (2) LIMITED LIABILITY CORPORATION _____

   (3) PARTNERSHIP ____

   (a) General ___

   (b) Limited ___

   (c) If General, where is it registered?
   County _____ State _____

   (d) If Limited, where is it registered? State _____

   (e) Is the limited partnership registered with the North Carolina Corporations Office?
   YES _____ NO _____

   (f) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

   Name: _____ Title: _____

   Address: _____ Percent of Ownership: _____

   Name: _____ Title: _____

   Address: _____ Percent of Ownership: _____

   Name: _____ Title: _____

   Address: _____ Percent of Ownership: _____

(4) CORPORATION ___

(a) Where was the corporation originally established? State _____

(b) List the names and addresses of ALL persons who have a 5% financial interest or more and the names of all officers:

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

Name: _____ Title: _____

Address: _____ Percent of Ownership: _____

(5) UNIT OF GOVERNMENT

(a) What is the name and title of the official in charge of the above governmental unit?

Name: _____

Title: _____

(b) Check the word which best describes the above type of governmental unit:

CITY ____ COUNTY ____ STATE ____ AUTHORITY ____

2. Does the licensee (legal entity: individual, partnership, corporation or unit) own the building from which services are offered? **YES** _____ **NO** _____

If **NO**, who owns the building?

Name: _____

Street/P.O. Box: _____

City: _____ State: _____ Zip: _____

Telephone: (___) _____ Fax: (___) _____

Note: If neither the building owner nor the lessee is shown as the license applicant, explain on a separate page.

3. Is this facility part of a multiple facility system **within North Carolina**? (A multiple facility system is defined as two or more nursing homes or health care facilities under the same ownership.)

YES _____ **NO** _____

If "YES", give the name and address of the multiple facility system (**Parent Company**) located within North Carolina.

a. Name of the Parent Company: _____

b. Address: _____ c. City: _____
(Street/PO Box)

d. State: _____ e. Zip: _____-_____

f. Telephone: (_____) _____ g. Fax: (_____) _____

h. Name of Senior Officer: _____

4. Does the facility operate under a management contract?

YES _____ **NO** _____

If "YES", give the name, address and name of chief executive officer of the organization that manages the facility.

a. Name of Organization: _____

b. Address: _____ c. City: _____
(Street/P O Box)

d. State: _____ e. Zip: _____-_____

f. Telephone: (_____) _____ g. Fax: (_____) _____

h. Name of Chief Executive Officer: _____

PART B OPERATIONS

PROVIDE NAMES FOR THE FOLLOWING:

1. FACILITY PERSONNEL
   a. Full-time administrator as required in 10A NCAC 13D .2201(c).

      Name of Administrator: _____
      Date Hired As Administrator: _____ N. C. License No.: _____

   b. Nursing

      1. Director of Nursing: _____
         License Number: _____ Date Hired as DON: _____
      2. Nurse Aide Training Program Coordinator: _____
      3. Nurse Aide Training Program Instructor: _____

   c. Activity Director: _____

   d. Dietary Services Director: _____

   e. Social Services Director: _____

2. MEDICAL AND DENTAL STAFF FOR EMERGENCY CALL
   a. Medical Director's Name Address

      1. _____ _____
         _____ _____
         _____ _____

   b. Dentist(s) Name(s) Address(es)

      1. _____ _____
      2. _____ _____
      3. _____ _____

3. CONTRACT/OTHER PERSONNEL OR CONSULTANTS

   a. Physical Therapist: _____
   b. Occupational Therapist: _____
   c. Speech Therapist: _____
   d. Medical Records: _____
   e. Pharmacy Consultant: _____
   f. Dietary Consultant: _____
   g. Other (i.e. Respiratory Therapist): _____

4. PHARMACY

   a. Source of Drugs:
      1. Do you have a pharmacy located in your facility? **YES** _____ **NO** _

      2. If "YES", please complete:

         Pharmacist Manager: _____

   b. If a pharmacy is not located in your facility, what is the name of the pharmacy from which drugs are obtained?

      Name: _____
      Street Address: _____
      City, State, Zip: _____

PART C PATIENT SERVICES

1. Continuing Care Retirement Communities (CCRC)

   a. Is the facility licensed by the Department of Insurance as a "Continuing Care Retirement Community"? a. **YES** ____ **NO** ____

   b. If the facility has Retirement Beds, indicate total number of these beds. Do not include nursing or "Adult Care Home" beds. b. _____

   c. If the CCRC owns or operates a licensed home care agency provide the agency license number: c. _____

2. Does the facility have an adult day care program? 2. **YES** ____ **NO** ____
   If "Yes", indicate maximum number of clients that can be served on a daily basis. _____

3. Does the facility provide hospice care? 3. **YES** ____ **NO** ____

4. Does the facility have an adult respite program? 4. **YES** ____ **NO** ____

5. Is the facility a "Combination Facility", thereby incorporating licensed ACH beds? 5. **YES** ___ **NO** ___
   If "Yes", indicate which rules the facility chooses to apply to the operation of these ACH beds. Nursing Home Licensure _____ ACH Licensure___
   *(NH Licensure rules only, ACH rules only, or both NH & ACH licensure rules.** Complete checklist if using both sets of rules.)*

6. **NUMBER OF BEDS BY TYPE (*Must complete required data supplement form)**

   a. **Nursing Beds (NF)** **(TOTAL)** a. _____

   1. Non-specialized/General Nursing Facility Beds 1. _____
   2. *Alzheimer's Special Care Unit Patient Beds 2. _____*
   3. HIV/AIDS Patient Beds 3. _____
   4. Traumatic Brain Injury Patient Beds 4. _____
   5. Ventilator Dependent Patient Beds 5. _____
   6. Other: (Specify) _____ 6. _____

   b. **Adult Care Home (ACH)** **(TOTAL)** b. _____
   (personal care with occasional or incidental nursing care only)

   1. Non-specialized/General Adult Care Home Beds 1. _____
   2. Mental Health Disability Special Care Unit Beds 2. _____
   3. *Alzheimer's Special Care Unit Resident Beds 3. _____*

   c. **TOTAL LICENSED BEDS** **(TOTAL a & b)** c. _____

PART D CURRENT OPERATING STATISTICS

Current Per Diem Reimbursement Rates/Charges.
Please state the CURRENT (today's date or date the application is signed) basic daily charges/rates for patients or residents in your facility in the following categories of care.

*** IF YOU HAVE QUESTIONS ON HOW TO COMPLETE THE FORM CALL 919-855-3873.**

Private Pay (Usual Customary Charge)	Private Room (1 bed/room)	Semi-Private (2 beds/room)	Ward
Nursing Care	$	$	$
Adult Care Home	$	$	$
Special Care Unit (specify)_____	$	$	$
Special Care Unit (specify)_____	$	$	$

Medicare	Code	Rate
Three most frequent RUGS codes and rates paid for them.	1.	$
	2.	$
	3.	$

	Quarterly Rates			
Medicaid	Oct.-Dec.	Jan.-Mar.	Apr.-June	July-Sept.
Nursing Care	$	$	$	$

Medicaid Nursing Care	Current Rate
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

State/County Special Assistance	Rate
Adult Care Home	$
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

Please complete only if applicable:

Alzheimer's/Dementia Special Care Unit	Rate
Additional cost or fee to resident	$

(Use reverse side or separate sheet if needed)

PART E TOTAL CURRENT STAFF FOR EXISTING FACILITY

Do not include the following: courtesy or attending staff, private duty nurses, volunteer workers or the same employee in more than one category. These employees were or will be on payroll as of _____.*
month / day / year

*** New facilities should complete according to the facility staffing level on date of Licensure.**

***This data is collected for the Certificate of Need Section. For questions call (919) 855-3873.**

	TOTAL FACILITY			
	AVERAGE ANNUAL SALARY	**HOURLY CONSULTANT FEE**	**FTE's**	**ANNUAL CONSULTANT HOURS**
ROUTINE SERVICES				
Registered Nurses				
LPNs				
Certified Nurse Aides				
Medical Director				
Director of Nurses				
Staff Devel. Coordinator				
Ward Secretary				
Medical Records				
Pharmacy Consultant				
ADMINISTRATION & GENERAL				
Administrator				
Asst. Administrator				
Other Office Personnel				
DIETARY				
Licensed Dietitian				
Food Services Supervisor				
Cooks				
Dietary Aides				
SOCIAL WORK SERVICES				
Social Services Director				
Social Services Asst.				
ACTIVITY SERVICES				
Activity Director				
Activity Assistant(s)				
Activity Consultant				
HOUSEKEEPING/LAUNDRY				
Housekeeping Supervisor				
Laundry Supervisor				
Housekeeping Aides				
Laundry Aides				
MAINTENANCE				
Maintenance Supervisor				
Janitors				
ANCILLARY SERVICES				
Physical Therapist				
PT/Rehabilitation Aide				
Occupational Therapy				
Speech/Hearing Therapy				
Respiratory Therapist				
Other (Specify)				
TOTAL POSITIONS/TOTAL CONSULTANT HOURS				

PART F LICENSE FEE

A non-refundable license fee is required and must accompany this application prior to the issuance of a nursing home license. The payment should be in the form of check, certified check or money order and must be made payable to: "**The Division of Facility Services**". Payment should include the facility's license number (if applicable) and be submitted with your license application. A separate check is required for each licensed entity.

******Please read carefully:** ****

Effective March 1, 2006, license fees will be pro-rated based on the month the application is mailed and postmarked during the year. **All license fees are nonrefundable regardless of when a license is finally issued.**

Annual License Fee Calculation:

1.

a. Total number of Licensed beds (must match 6c. from page 6)	
b. Multiply by per bed fee	x $12.50
c. Total per bed fee (sum of multiplication of 1a. and 1b.)	$

2.

a. Total bed fee (from 1c. above)	$
b. Add $450.00 (base fee)	+ $450.00
c. Total Annual Fee (addition of 2a. and 2b.)	$

Pro-rated Fee Calculation:

3. **Must** complete #1 and #2 above to determine annual fee amount from which to pro-rate

a. Total Annual Fee (from 2c. above)	$
b. Multiply by month factor (see chart below)	x _____ month factor
c. Total Pro-rated Annual Fee (sum of multiplication of 3a. and 3b.)	$

Month application mailed and postmarked for submission to agency and corresponding rate factor:

Month	Factor
January	1.0
February.	0.92
March	0.83
April	0.75
May	0.67
June	0.58
July	0.50
August.	0.42
September	0.33
October	0.25
November	0.17
December	0.08

This application must be completed and submitted to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation, with the license fee, prior to the issuance of a nursing home license. The license fee is non-refundable. The legislation (SB 622, Session Law 2005-276) prohibits a license from being issued if the fee has not been paid.

The undersigned submits this application for licensure for the year 2007 {subject to the provisions of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission} and certifies the accuracy of this information.

_____ _____

Typed Name of Chief Administrative Officer or Authorized Official

(Written Signature)

Title: _____ Date: _____

Please identify the contact person for questions regarding this application:

Name: _____ Telephone: (____) _____